January 25, 2008

HOUSE BILL No. 1323

DIGEST OF HB 1323 (Updated January 23, 2008 3:08 pm - DI 97)

Citations Affected: IC 27-8; IC 27-13; noncode.

Synopsis: Dialysis treatment coverage. Specifies requirements for an accident and sickness insurer and a health maintenance organization with respect to providing coverage for dialysis treatment, including payment rates, changes in coverage, claim payments, networks of dialysis treatment providers, and filings.

Effective: Upon passage.

Fry

January 15, 2008, read first time and referred to Committee on Insurance.
January 24, 2008, amended, reported — Do Pass.

January 25, 2008

Second Regular Session 115th General Assembly (2008)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2007 Regular Session of the General Assembly.

HOUSE BILL No. 1323

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 10. (a) As used in this section, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.**

(b) As used in this section, "contracted dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under section 3 of this chapter.

(c) Notwithstanding section 1 of this chapter, as used in this section, "insured" refers only to an insured who requires dialysis treatment.

(d) As used in this section, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) An agent of an insurer.

(e) As used in this section, "non-contracted dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under section 3 of this chapter.

(f) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance policy issued as an individual policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(g) An insurer shall establish a payment rate for a health care service rendered by a dialysis treatment provider at a non-contracted dialysis facility based on the following:

(1) The type of health care service rendered.

(2) The fees usually charged by the dialysis treatment provider.

(3) The prevailing rate paid to a dialysis treatment provider by insurers in the same geographic area during the preceding twelve (12) months.

(h) In establishing a payment rate under subsection (g), an insurer shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greater of the following payment rates paid by the insurer during the previous twelve (12) months:

(A) The payment rate paid to the dialysis treatment provider for health care services rendered at a contracted dialysis facility.

(B) The payment rate paid to the dialysis treatment provider for health care services rendered at a non-contracted dialysis facility.

(C) The payment rate paid to any dialysis treatment provider for health care services rendered at a contracted dialysis facility.

(i) An insurer may not do any of the following at any time after

the insured elects coverage under a group policy of accident and sickness insurance:

(1) Restrict benefits or increase costs to an insured in relation to dialysis treatment, including the insured's out of pocket expenses.

(2) Change coverage or benefits in any way that would affect dialysis treatment provided at a non-contracted dialysis facility.

(j) An insurer shall not do the following:

(1) Make changes in coverage under a policy of accident and sickness in an attempt to cause an insured to elect Medicare as the insured's primary coverage.

(2) Require an insured, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the insured's home to obtain dialysis treatment, regardless of whether the insured chooses to receive dialysis treatment at a contracted dialysis facility or a non-contracted dialysis facility.

(3) Interfere with a physician's treatment of an insured.

(k) An insurer shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the insured, regardless of whether the health care services are provided in a contracted dialysis facility or a non-contracted dialysis facility.

(2) File with the department an annual evaluation of whether the insurer's network of all dialysis treatment providers is sufficient to provide health care services to insureds covered under a policy of accident and sickness insurance issued by the insurer.

(3) File with the department an annual evaluation of whether the insurer is in compliance with this section.

(4) Before any proposed change to the network, the insurer shall:

(A) file with the department an analysis of the manner in which the proposed change will affect insured access to dialysis treatment, quality of care, and premium rates; and

(B) demonstrate to the commissioner that the proposed change will not result in a shift of coverage from commercial health coverage to government funded coverage for insureds who will be affected by the proposed change.

(5) The insurer may not implement a proposed change described in subdivision (4) until the commissioner approves the proposed change.

(6) The network must at all times include not less than fifty percent (50%) of the dialysis facilities in the geographic area in which health care services are provided by the network.

(l) The commissioner shall, not more than thirty (30) days after receiving a filing under subsection (k)(2), approve the filing or make recommendations for changes to the network.

(m) The department may adopt rules under IC 4-22-2 to implement this section.

SECTION 2. IC 27-13-1-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.5. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.**

SECTION 3. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.**

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) A health maintenance organization shall establish a payment rate for a health care service rendered by a dialysis treatment provider at a dialysis facility that is not a participating provider based on the following:

(1) The type of health care service rendered.

(2) The fees usually charged by the dialysis treatment provider.

(3) The prevailing rate paid to a dialysis treatment provider by health maintenance organizations in the same geographic area during the preceding twelve (12) months.

(d) In establishing a payment rate under subsection (c), a health maintenance organization shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greater of the following payment rates paid by the health maintenance organization during the previous twelve

(12) months:

(A) The payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.

(B) The payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis facility that is not a participating provider.

(C) The payment rate paid to any dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.

(e) A health maintenance organization may not do any of the following at any time after which the enrollee elects coverage under a group contract:

(1) Restrict benefits or increase costs to an enrollee in relation to dialysis treatment, including the enrollee's out of pocket expenses.

(2) Change coverage or benefits in any way that would affect dialysis treatment provided at a dialysis facility that is not a participating provider.

(f) A health maintenance organization shall not do the following:

(1) Make changes in coverage under an individual contract or a group contract in an attempt to cause an enrollee to elect Medicare as the enrollee's primary coverage.

(2) Require an enrollee, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the enrollee's home to obtain dialysis treatment, regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(3) Interfere with a physician's treatment of an enrollee.

(g) A health maintenance organization shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the enrollee, regardless of whether the health care services are provided in a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(2) File with the department an annual evaluation of whether the health maintenance organization's network of all dialysis treatment providers is sufficient to provide health care services to enrollees covered under an individual contract or

a group contract entered into by the health maintenance organization.

(3) File with the department an annual evaluation of whether the health maintenance organization is in compliance with this section.

(4) Before any proposed change to the network, the health maintenance organization shall:

(A) file with the department an analysis of the manner in which the proposed change will affect enrollee access to dialysis treatment, quality of care, and premium rates; and

(B) demonstrate to the commissioner that the proposed change will not result in a shift of coverage from commercial health coverage to government funded coverage for enrollees who will be affected by the proposed change.

(5) The health maintenance organization may not implement a proposed change described in subdivision (4) until the commissioner approves the proposed change.

(6) The network must at all times include not less than fifty percent (50%) of the dialysis facilities in the health maintenance organization's service area.

(h) The commissioner shall, not more than thirty (30) days after receiving a filing under subsection (g)(2), approve the filing or make recommendations for changes to the network.

(i) The department may adopt rules under IC 4-22-2 to implement this section.

SECTION 4. [EFFECTIVE UPON PASSAGE] **(a) The department of insurance shall, not later than July 31, 2008, conduct a comprehensive review of filings made with the department of insurance:**

(1) by an insurer described in IC 27-8-11, as amended by this act, to determine compliance with IC 27-8-11, as amended by this act; and

(2) by a health maintenance organization described in IC 27-13-15-5, as added by this act, to determine compliance with IC 27-13-15-5, as added by this act.

(b) If the department of insurance determines that an insurer or health maintenance organization is not in compliance, as described in subsection (a), the department of insurance shall notify the insurer or health maintenance organization of the noncompliance, and the insurer or health maintenance organization shall prove compliance not later than sixty (60) days after the insurer or health

maintenance organization receives notice of noncompliance under this subsection.

(c) An insurer described in IC 27-8-11, as amended by this act, and a health maintenance organization described in IC 27-13-15-5, as added by this act, shall do the following:

(1) The insurer shall inform the department of insurance of any violation by the insurer of IC 27-8-11, as amended by this act, and correct the violation not later than sixty (60) days after providing notice to the department of insurance under this subdivision.

(2) The health maintenance organization shall inform the department of insurance of any violation by the health maintenance organization of IC 27-13-15-5, as added by this act, and correct the violation not later than sixty (60) days after providing notice to the department of insurance under this subdivision.

(d) Failure of an insurer or a health maintenance organization to comply with subsection (b) or (c) of this SECTION is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 5. [EFFECTIVE UPON PASSAGE] **(a) IC 27-8-11-10, as added by this act, applies to an agreement between an insurer and a dialysis treatment provider that is entered into, amended, or renewed on or after April 30, 2008.**

(b) IC 27-13-15-5, as added by this act, applies to a contract between a health maintenance organization and a dialysis treatment provider that is entered into, amended, or renewed after April 30, 2008.

SECTION 6. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1323, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Replace the effective dates in SECTIONS 1 through 4 with "[EFFECTIVE UPON PASSAGE]".

Page 1, line 3, after "(a)" insert "**As used in this section, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.**

(b) As used in this section, "contracted dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under section 3 of this chapter.

(c)".

Page 1, line 6, delete "(b)" and insert "**(d)**".

Page 1, between lines 8 and 9, begin a new paragraph and insert:

"**(e) As used in this section, "non-contracted dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under section 3 of this chapter.**".

Page 1, line 9, delete "(c)" and insert "**(f)**".

Page 1, line 10, after "." insert "**The term does not include the following:**

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance policy issued as an individual policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.".

Page 1, delete lines 11 through 17.

Page 2, delete lines 1 through 14, begin a new paragraph and insert:

"**(g) An insurer shall establish a payment rate for a health care service rendered by a dialysis treatment provider at a non-contracted dialysis facility based on the following:**

(1) The type of health care service rendered.

(2) The fees usually charged by the dialysis treatment provider.

(3) The prevailing rate paid to a dialysis treatment provider by insurers in the same geographic area during the preceding twelve (12) months.

(h) In establishing a payment rate under subsection (g), an insurer shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greater of the following payment rates paid by the insurer during the previous twelve (12) months:

(A) The payment rate paid to the dialysis treatment provider for health care services rendered at a contracted dialysis facility.

(B) The payment rate paid to the dialysis treatment provider for health care services rendered at a non-contracted dialysis facility.

(C) The payment rate paid to any dialysis treatment provider for health care services rendered at a contracted dialysis facility.".

Page 2, line 15, delete "(e)" and insert "**(i)**".

Page 2, line 16, delete "the open enrollment period during which".

Page 2, line 16, delete "becomes" and insert "**elects coverage**".

Page 2, line 17, delete "covered".

Page 2, line 19, delete "unless the insured becomes eligible for" and insert "**including the insured's out of pocket expenses.**".

Page 2, delete lines 20 through 42, begin a new line block indented and insert:

"**(2) Change coverage or benefits in any way that would affect dialysis treatment provided at a non-contracted dialysis facility.**

(j) An insurer shall not do the following:

(1) Make changes in coverage under a policy of accident and sickness in an attempt to cause an insured to elect Medicare as the insured's primary coverage.

(2) Require an insured, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the insured's home to obtain dialysis treatment, regardless of whether the insured chooses to receive dialysis treatment at a contracted dialysis facility or a non-contracted dialysis facility.

(3) Interfere with a physician's treatment of an insured.

(k) An insurer shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the insured, regardless of whether the health care services are provided in a contracted dialysis facility or a non-contracted dialysis facility.

(2) File with the department an annual evaluation of whether the insurer's network of all dialysis treatment providers is sufficient to provide health care services to insureds covered under a policy of accident and sickness insurance issued by the insurer.

(3) File with the department an annual evaluation of whether the insurer is in compliance with this section.".

Page 3, delete lines 1 through 37.

Page 3, line 38, delete (2) and insert "**(4)**".

Page 4, line 6, delete "(3)" and insert "**(5)**".

Page 4, line 7, delete "(2)" and insert "**(4)**".

Page 4, line 9, delete "(4)" and insert "**(6)**".

Page 4, line 9, delete "seventy" and insert "**fifty percent (50%) of the dialysis facilities in the geographic area in which health care services are provided by the network.**".

Page 4, delete lines 10 through 13, begin a new paragraph and insert:

"**(l) The commissioner shall, not more than thirty (30) days after receiving a filing under subsection (k)(2), approve the filing or make recommendations for changes to the network.**".

Page 4, line 14, delete "(k)" and insert "**(m)**".

Page 4, between lines 15 and 16, begin a new paragraph and insert:

"SECTION 2. IC 27-13-1-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.5. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.**".

Page 4, delete lines 26 through 42, begin a new paragraph and insert:

"**(c) A health maintenance organization shall establish a payment rate for a health care service rendered by a dialysis treatment provider at a dialysis facility that is not a participating provider based on the following:**

(1) The type of health care service rendered.

(2) The fees usually charged by the dialysis treatment provider.

(3) The prevailing rate paid to a dialysis treatment provider by health maintenance organizations in the same geographic area during the preceding twelve (12) months.

(d) In establishing a payment rate under subsection (c), a health maintenance organization shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greater of the following payment rates paid by the health maintenance organization during the previous twelve (12) months:

(A) The payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.

(B) The payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis facility that is not a participating provider.

(C) The payment rate paid to any dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.".

Page 5, delete lines 1 through 3.

Page 5, line 4, delete "(d)" and insert "**(e)**".

Page 5, line 5, delete "the open enrollment period during".

Page 5, line 6, delete "becomes covered" and insert "**elects coverage**".

Page 5, line 8, delete "unless the enrollee becomes eligible for" and insert "**including the enrollee's out of pocket expenses.**".

Page 5, delete lines 9 through 42, begin a new line block indented and insert:

"**(2) Change coverage or benefits in any way that would affect dialysis treatment provided at a dialysis facility that is not a participating provider.**

(f) A health maintenance organization shall not do the following:

(1) Make changes in coverage under an individual contract or a group contract in an attempt to cause an enrollee to elect Medicare as the enrollee's primary coverage.

(2) Require an enrollee, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the enrollee's home to obtain dialysis treatment, regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(3) Interfere with a physician's treatment of an enrollee.

(g) A health maintenance organization shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the enrollee, regardless of whether the health care services are provided in a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(2) File with the department an annual evaluation of whether the health maintenance organization's network of all dialysis treatment providers is sufficient to provide health care services to enrollees covered under an individual contract or a group contract entered into by the health maintenance organization.

(3) File with the department an annual evaluation of whether the health maintenance organization is in compliance with this section.".

Page 6, delete lines 1 through 25.

Page 6, line 26, delete (2) and insert "**(4)**".

Page 6, line 36, delete "(3)" and insert "**(5)**".

Page 6, line 37, delete "(2)" and insert "**(4)**".

Page 6, line 39, delete "(4)" and insert "**(6)**".

Page 6, line 39, delete "seventy" and insert "**fifty percent (50%) of the dialysis facilities in the health maintenance organization's service area.**".

Page 6, delete lines 40 through 42, begin a new paragraph and insert:

"**(h) The commissioner shall, not more than thirty (30) days after receiving a filing under subsection (g)(2), approve the filing or make recommendations for changes to the network.**".

Page 7, delete lines 1 through 2.

Page 7, line 3, delete "(j)" and insert "**(i)**".

Page 7, line 6, delete "December" and insert "**July**".

Page 8, line 2, delete "June" and insert "**April**".

Page 8, line 6, delete "June" and insert "**April**".

Page 8, after line 6, begin a new paragraph and insert:

"SECTION 6. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1323 as introduced.)

FRY, Chair

Committee Vote: yeas 8, nays 3.